KING COUNTY BOARD OF HEALTH
999 Third Avenue, Suite 1200
Seattle, Washington 98104-4039

Carolyn Edmonds, *Board of Health Chair*

KING COUNTY BOARD OF HEALTH MEETING PROCEEDINGS

July 19, 2002
Harborview Medical Center Auditorium

Roll call

Carolyn Edmonds
Dow Constantine
Kent Pullen
Larry Gossett,
Richard Conlin
Ava Frisinger
Margaret Pageler
Joseph Pizzorno
Alvin Thompson
Karen Van Dusen

Members absent: Richard Conlin, Kathy Lambert, David Hutchinson, Jan Drago

Call to order

The meeting was called to order at 9:45 a.m. by Board Chair, Carolyn Edmonds who welcomed the Board, staff, and members of the public to the Harborview Medical Center. Chair Edmonds commented that holding Board meetings off-site in her estimation added to the richness of their experience as Board members and allowed the Board to become educated about the work of Public Health in the community. Chair Edmonds extended her thanks to the staff from CTV for making special arrangements to tape the meeting so that residents of King County could have the benefit of the Board of Health meeting proceedings. Chair Edmonds briefly described the unique partnership between Harborview Medical Center and Public Health; especially noting those Public Health services and programs co-located on the Harborview campus - namely the Medical Examiner's Office, STD and TB Clinics, Public Health Lab and the Northwest Family Center.

Chair Edmonds acknowledged Mr. David Jaffe, Harborview Executive Director and CEO. Mr. Jaffe welcomed the Board and the public to the Harborview Campus. He touched on a few of the highlights of the Harborview-Public Health partnership especially the work currently being carried out related to bioterrorism response and planning. He introduced his colleague, Ms. Elise Chayet - Director of Planning, whom he indicated, would be addressing the Board later on in their agenda.

On request by Chair Edmonds, Mr. Jaffe provided an overview of the size and scope of Harborview as summarized below:

- County-owned facility, managed by the University of Washington. An arrangement very unique that began in 1967 when the first management agreement was signed.
- $379 million net revenue budget; gross budget in excess of $500 million.
- Operating certificate for 413 beds. Currently operating at about 374 beds, with an average of 100% occupancy rate for those 374 beds.
- Mission - to serve selected high priority populations including victims of sexual assault, victims of domestic violence, incarcerated persons, victims of serious trauma and burn, and the mentally ill.
- Completed a $179 million building program in 1997, which included a major seismic upgrade to the facility, replaced the trauma facility, added an ambulatory care wing and then reconfigured many of the departments that support those facilities.
- Currently undertaking a seismic upgrade of the remaining buildings in light of new information about the Seattle fault and the vulnerability of Harborview.
- Bond measure passed which would allow for seismic upgrades to older buildings and add 50 critical care beds.

Announcement of Alternates

No alternates in attendance.

Approval of May 17, 2002 Minutes

Discussion: None.

Motion: A motion was made to approve the minutes of May 17, 2002. The motion was seconded and passed unanimously.

General Public Comments

There were no public comments.

Chair's Report - Carolyn Edmonds

A. **Budget Workshop:**
Chair Edmonds noted that the next Board meeting was scheduled for Friday, August 23rd and would be a Board work session on the Department budget. She pointed out that the meeting on the 23rd - the fourth Friday- would replace the regularly scheduled Board meeting generally held on the third Friday of each month. She added that the meeting would be held on the 12th floor of the County Courthouse in the Southwest Conference Room.

B. **Joint meeting with State Board of Health:**
Chair Edmonds announced that the December Board meeting would be a joint meeting with the State Board of Health, scheduled for December 10th at a SeaTac area location. She added that the meeting on December 10th would be in lieu of the regularly scheduled December meeting on December 20th. Chair Edmonds stated that details of this meeting would be forthcoming at a future date.

C. **Washington Association of Counties update:**
Chair Edmonds announced that she would be attending the WSAC Legislative Steering Committee the week of the 20th. She noted that the focus of the meeting was to

establish legislative priorities and strategies for the 2003 legislative session. Chair Edmonds stated her objective was to assure that public health funding is identified as a priority issue for the WSAC legislative agenda.

D. **Health Professional Member Recruitment:**
Chair Edmonds stated that the three health professional members, Dr. Thompson, Dr. Pizzorno and Ms. Van Dusen, would be stepping down at the turn of the year due to term limits. She noted that they had each served on the Board with due diligence and had contributed greatly with their depth and breadth of experience and skills. In anticipation of these planned retirements, Chair Edmonds called for volunteers to serve on an ad hoc recruitment committee.

Discussion: Chair Edmonds volunteered to serve on the Committee. Board Member Pullen inquired if the three seated Health Professional members were eligible to serve on the Committee. He noted that the current members had done an outstanding job and all three of them played an important role and had special skills that could facilitate finding their replacements.

Chair Edmonds inquired of the three health professional member's interest and willingness to serve on the Committee. All three agreed to serve on the Committee. The Ad Hoc Recruitment Committee will consist of Chair Edmonds and Board Members Pizzorno, Thompson and Van Dusen. Board Staff will convene the first meeting of the Committee in early September.

Other: Board Member Pageler asked to revisit the subject of the Budget Workshop. Board Member Pageler noted that the City Council of Seattle would be on recess the last two weeks of August. She requested that senior staff from the Mayor's office or from the Council be invited to attend if Council members were unable to do so. She added that it would be advantageous to have representatives from the City of Seattle who were knowledgeable and committed to public health issues and in a position to make some key strategic decisions. Chair Edmonds concurred that it would be advantageous to have representation from the City of Seattle.

Director's Report -- Alonzo Plough

A. **Introduction of new Department Executive Leadership:**
Dr. Plough introduced two new members of his Executive Leadership Team: Greg Kipp and Dorothy Teeter. Dr. Plough stated that Mr. Kipp, the new Chief Administrative Officer came to Public Health from a long and distinguished history as a Department head in King County government. He stated that Mr. Kipp had also served as an Assistant Director of the Seattle Budget Office. Dr. Plough stated that Ms Teeter was well known in public health and health circles in Seattle and King County. He added that Ms. Teeter was a former Senior Vice President with Group Health and in that capacity had been involved in the areas of quality assurance, clinical integration, and clinical management information services.

B. **Bioterrosim Planning Update:**
Dr. Plough noted that he had attended the first meeting of the statewide task force on bioterrorism; a group convened to advise the State on BT related expenditures and provide guidance and expertise related to planning and preparedness. Dr. Plough noted that the task force had broad representation including variety of first responders - fire, police, and emergency management from throughout the state. He stated that the challenge for the task force was to, interpret the Statewide mandate for preparing

communities and secondly to quickly align around the more expansive definition of biological agents and corresponding preparedness that went well beyond the types of hazardous materials and chemicals most first responders were familiar with. He added that much of their work prospectively would be to educate their partners around the very different kinds of roles Public Health and others played in a biological response.

C. **Briefing:**
Communicable Disease Prevention and Control: Dr. Plough noted that the US Centers for Disease Control and the United States Health & Human Services had developed interim guidance related to the provision of smallpox vaccination to an estimated 500,000 pre-designated individuals around the country as part of the bioterrorism and smallpox response plan. Dr. Plough stated that he had already received e-mails from local first responders and from Public Health employees regarding the implications of this guidance and forthcoming policy. He stated that there needed to be planning related to the logistics of predetermining who would receive the vaccination as well as providing public about the stages of protection. Dr. Plough commented that there was a tremendous amount of work that needed to be accomplished and he wished they were better funded and had better capacity to do that at this point.

Discussion: Dr. Thompson inquired as to whether or not the Department had looked at the legal aspects, and the possible public relations and education concepts, related to quarantine.

Dr. Plough stated that they had looked at those issues. Dr. Jeff Duchin, Chief of Communicable Disease section, responded that they had convened all the hospitals in the region around quarantine planning, and that they had established collaborative committees between the Health Department and area health providers around the quarantine procedures and protocols needed by authorities in the event of an outbreak or other event. Dr. Duchin stated that there was also work being undertaken by the State Board of Health relative to the statutory authority that would be needed to implement quarantine procedures. Although he added that it was generally believed that such powers were vested in local health authorities under older statutory language.

Board Member Thompson commented that we were in a different time than when quarantine was last exercised, and he had in mind educating the public so that there would be consent rather than all kinds of difficulties that could occur.

Dr. Plough stated that he and Dr. Duchin had recently participated in an interview with a National Public Radio correspondent on that issue. Dr. Plough stated that one of his biggest concerns with the level of federal funding was that it would not be sufficient to address the major shortfall in community education and engagement activities. He added that the Department could undertake extensive epidemiological driven and clinically driven planning but if they didn't engage the community as partners in understanding the context of the disease and the right amount of public awareness versus paralyzing fear, that they were not going to be able to implement those strategies.

Board Member Pizzorno asked the following questions: Why smallpox rather than other diseases? Had there been evaluation of the side effects of all those vaccinations and severity of those side effects versus the probability of exposure? Were Public Health Officials involved in a homeland security neighborhood watch program being implemented, and if so, how were they going to handle all those issues of privacy and property rights?

Dr. Plough responded that he could answer Board Member Pizzorno's first and second questions, but would defer to Dr. Duchin on the third.

Dr. Plough responded that generically speaking, vaccines were an important prevention tool for Public Health. Dr. Plough emphasized the general safety of vaccines particularly related to childhood preventable diseases and the great progress made in King County to eliminate outbreaks in those areas. Relative to the relationship between homeland security and local Public Health, he responded that there had not been a local health perspective and the appropriate linkages. He indicated that the current configuration needed to be revisited because the citizen network as a connection between a federally based website and local communities bypassed both local and state health departments.

Board Member Van Dusen asked if the December joint meeting with the State Board of Health might be an opportunity to raise concerns about bioterrorism planning and preparedness.

Chair Edmonds indicated that she would take that suggestion under advisement.

Board Member Pullen inquired whether or not the smallpox immunization program would be voluntary or mandatory for health care workers.

Dr. Plough responded that he believed it would be voluntary for the individuals who would need to be involved as predetermined first responders.

Board Member Pullen stated that prior statistics the Board heard on smallpox suggested that one out of a thousand people vaccinated had an extremely serious reaction and one out of some other higher number actually died. He asked if anyone had looked at the liability issues.

Dr. Plough responded that he would be looking at the liability issues very carefully and watching to see how the CDC implemented the program.

Dr. Plough introduced the briefing on communicable disease prevention and control. He stated that communicable diseases remained one of the major causes of illness and disability and death. He added that communicable disease control was a high priority for the Department. He introduced John Wiesman, Prevention Division Director, and Dr. Jeff Duchin, Chief of Communicable Disease Control.

Mr. Wiesman provided an orientation and overview of the Department's communicable disease program. The following are highlights from his presentation:

- 65 communicable diseases reportable to Public Health by physicians, health care providers, laboratories, schools, and employees. Different diseases have different time frames for reporting.
- The Department received these reports, looked at disease trends and reports on potential program changes based on the surveillance data.
- The Department conducted outbreak investigations, attempted to identify common sources of outbreaks in order to control them and/or remove the harmful product.
- The Department provided immunizations, monitored vaccination trends, provided provider education about current recommendations, changes in the vaccines, addresses vaccine shortages and distributed and oversaw vaccines for children distributed throughout the County and State.

- The Department provided bioterrorism surveillance, technical support for health care providers and institutions around reporting and potential diagnosis of cases, and how to treat and control them.

Challenges:

- Increase in number of reportable diseases. In 2000 - 1900 reportable confirmed cases to the Department. In 2001 -4,827. Increase primarily due to the reporting of Hepatitis B and C.
- Bioterrorism preparedness in terms of mobilizing and responding to the planning efforts; fiscal issues due to decreasing revenues while workload was increasing.

Dr. Duchin focused on four key issues: Smallpox, West Nile Virus, Pandemic Flu and the Vaccine Shortage. The following are highlights from his presentation:

Smallpox Vaccine:

- The Advisory Committee on immunization practices are a group of experts that are convened by the U.S. Centers for Disease Control and HHS to help them formulate a health policy and recommendations surrounding the use of vaccines in this country. Committee's guidance was then taken into account by CDC and CDC then translated Advisory Committee recommendations into action for state and local Health Departments.
- Smallpox doesn't occur naturally but it's causative agent, variola virus, does still exist. The problem was that it was not known with certainty whether or not the virus had been obtained by persons who might use it to cause intentional infections. Because the infection did not naturally occur the use of the vaccine must be based on the probability or risk of an intentional exposure during a bioterror event and that must be balanced by the risk of adverse effects due to the vaccine.
- Smallpox vaccine was associated with potentially severe adverse effects. A pre-exposure smallpox vaccination campaign for the U.S. public, the general public aged one to 65 could result in as many as 4,600 serious adverse events and 285 deaths among persons who are not at high risk for vaccine complications. Smallpox vaccination has not been advised by the Advisory Committee for persons with certain medical conditions [persons with HIV infection, persons with organ or bone marrow transplantation or therapy with immunosuppressive drugs, pregnant women, persons who have congenital immune deficiencies, or a history of a eczema or exfoliative dermatitis or other active skin condition] that place them at high risk for complications. In the absence of naturally occurring smallpox the Advisory Committee is not recommending routine vaccination of the general public or of health care workers before an attack.
- The Advisory Committee has recommended to HHS and CDC that each state develop a plan to immunize a limited and not yet specified number of teams and hospital staff that would be first responders predesignated to evaluate, investigate, care for, possibly transport initial cases of smallpox in the event of an outbreak or an attack. These teams would most likely include designated persons from the following high risk or priority groups for smallpox vaccination in the event of an outbreak, and those include health care workers, persons involved in the direct care, the medical care or Public Health management or transport of either suspected or confirmed cases, laboratory staff who need to process specimens from suspected or confirmed cases, other persons within the hospital who may be at increased risk for contact, direct contact with infectious materials, and persons who unhindered function is essential to support community-wide response activities.

- Next, the CDC/HHS administration will review the Advisory Committee recommendations and within the next several months additional policy and guidance will be forthcoming for state and local Health Departments. When those recommendations are available from CDC, Public Health will work closely with the State Health Department and CDC to develop the type of smallpox response teams that are possible to develop with the resources made available and to provide vaccine to designated high risk members of such teams.
- Should smallpox actually occur in the community, the vaccine, according to CDC, would be made widely available to persons exposed to a release of smallpox virus or to suspected cases in the context of suspected and confirmed cases as well as persons in those priority groups identified by the CDC smallpox response plan. If there were multiple cases of smallpox or if evidence suggested that there was more widespread dissemination of the virus in the community, then CDC would consider releasing vaccine for widespread use in the population.

Pandemic Influenza:

- The epidemic of 1918-19 killed more humans than any other disease in a period of similar duration in the history of the world. Trends in infectious disease mortality in the U.S. during the 20th Century, showed progressive decline in the mortality with the exception of the years 1918-1919 where there was a large spike in mortality. Over 21,000 deaths between September 6th and November 29th of 1918 due to influenza and pneumonia alone.
- The influenza pandemic of 1918, also referred to as the Spanish flu because it killed 8 million persons in Spain in May of 1918, probably originated in China. There were 20 to 40 million deaths worldwide and more persons died in a single year than in four years of the Black Death of bubonic plague in the 1300's. An estimated 43,000 servicemen mobilized for World War I died of influenza.
- Overall in the U.S. 675,000 Americans died, 10 times as many as in World War I. The average lifespan in the U.S. was depressed by 10 years. This outbreak was unique because the death rate was 25 times higher than that in previous influenza epidemics and the infection preferentially knocked off young, healthy people, which was unusual because it was usually children and the elderly and those who had medical problems that were affected by influenza.
- The virus changes each winter. The virus is composed of several different proteins and those proteins rearrange themselves every winter so that our immune systems don't recognize the virus from last season which thereby necessitating a new immunization each year. The virus is able to change because there are different components of influenza viruses that live in influenza viruses of animals particularly ducks and geese as well as horses and pigs. Those viruses can infect different animals, rearrange their genetic material and can infect humans and new human viruses can arise.
- Currently there are three types circulating worldwide and they're divided and characterized based on their proteins called H and N proteins and current subtypes are H1, N1 and H3N2.
- Since 1918 several pandemic strains have arrived in the U.S. 1918-19 strain resulted in 20 million deaths worldwide, over half a million in the U.S. In 1957-58 we had the Asian flu which resulted in 70,000 excess deaths in the U.S. In 1968-69 we had the Hong Kong flu which was blamed for 34,000 excess deaths in the U.S. And that began what was called the H3N2 era and since that time we've had over 400,000 deaths due to that strain of influenza virus in the U.S. In 1977 an H1N1 strain reemerged and has been circulating ever since.
- The next pandemic is inevitable. Need to plan for a recurrence of one of these new strains of influenza that will make its way into the population. The objective of the

planning then would be to reduce the mortality, morbidity, social disruption and economic losses. There will probably be only between one and six months between the detection of the new strain and the outbreaks occurring in the U.S. The effect will be prolonged - weeks to months.

- National influenza preparedness planning, emphasizes integrating influenza pandemic planning into emergency preparedness plans that already exist, to incorporate the new features such as drug and vaccine delivery and Public Health surveillance, to develop a mitigation strategy including understanding the widespread nature of the health effects and disruption of the human infrastructure.
- Public Health needs to, establish high priority groups for vaccination, and need to be able to maintain community infrastructure and minimize social disruption and economic losses. Need to have a vaccine prioritization scheme for different levels of vaccine shortages and be able to have a flexible plan that we can adjust based on the epidemiological features of the pandemic.
- Potential impact of pandemic influenza has been modeled and it's thought that up to 200 million persons may be infected with 40 to 100 million ill, and 18 to 45 million requiring some type of medical care. Up to 800,000 person's hospitalized and 300,000 deaths. The economic costs would be very high, up to $166 billion in the models.
- Vaccine and antiviral drugs would be in very short supply - six to eight month lag time between the detection of a new strain and the manufacturing process needed to produce the vaccine. Health care workers and other first responders are going to be at highest risk of exposure and illness, higher than the general population because of the number of contacts they have with ill people in their day-to-day occupations. Added risk of sudden shortages of key personnel and critical community services such as health care, police, fire, utilities, transportation and air traffic controllers would be a big concern.
- Vaccine delivery would be the central preventive strategy. The target population would be expanded in contrast with smallpox to include the entire population. Central issues include a very short time frame for vaccine delivery, distribution and administration; severe or moderate shortage of vaccine; and security issues.

Immunization Program:

- Important issues in the immunization program: including vaccine shortages, cost increases for vaccine, the depressed economy in general, decreases in Medicaid coverage, more shots being recommended at younger and younger ages, the impact of the anti-vaccine movement, generic anti-government sentiment, and of course the emphasis on rapid response due to the bioterrorism attack.
- Vaccination coverage rates for 19 to 35 months olds in King County and Washington State nationally, for routine childhood immunizations, downward trend since 1998.
- Possible factors contributing to the national vaccine shortages of diphtheria, tetanus and the acellular pertussis vaccine, tetanus toxoid, measles, mumps and rubella, varicella vaccine and of the new extremely effective pneumococcal conjugate vaccine for young children:

    - Withdrawal from the market by some manufacturers because no longer lucrative business.
    - Difficulties in the manufacturing processes particularly the type of stringent, but good manufacturing processes that were required by the FDA, and sanctions that led to interruptions in manufacturing.
    - Temporary shutdowns of facilities for routine maintenance or upgrades came at a bad time.
    - Transition to thymersol-free vaccines because of the concern about very low levels of mercury exceeding one of the two federal thresholds for safety.

- Currently have adequate supplies to resume our routine childhood immunization schedules and start re-immunizing children.
- Immunization program growth between 1996 and 1999 from 323,000 to 624,000 doses. A vast majority of those doses are provided by private community health care providers, immunization providers whom the Department works with to provide the vaccine and to monitor their compliance with good standards and practices for administering the vaccine appropriately, safety issues and vaccine storage issues. Tremendous increase in workload for immunization program staff due to increase in the number of providers who were participating in the program, and an increased amount of oversight the Department exercised over administration of vaccine to ensure that they were administered safely.

West Nile virus:

- West Nile virus is a virus related to Japanese encephalitis virus and St. Louis encephalitis virus. Encephalitis is a medical condition that is reportable in Washington. There are many types of encephalitis, which the Department does surveillance for including Western equine, St. Louis encephalitis, mumps, measles, rubella, lymphocytic correomeningitis virus, enteroviruses, rabies and herpesvirus. The virus transmits itself in a cycle between mosquitoes and birds, and humans and horses are incidental infections.
- Number of factors that go into determining whether or not West Nile virus will move effectively from a bird to a mosquito and from a mosquito back to a bird. There are lots of factors such as weather, climate, food, space, and breeding sites that go into determining whether or not the breeding cycle will be effective in mosquitoes so that the disease can be sustained in a community.
- West Nile virus was first described in 1941 in Israel and outbreaks has been described in many countries throughout the world since that time. Appear to be more recent and frequent outbreaks and an apparent increase in severity of the illness.
- West Nile was identified in the United States in 1999. There were two cases of encephalitis and muscle weakness reported by a physician who happened to see both of those cases. Eventually there were a total of sixty-three cases identified.
- Lessons learned from West Nile virus in New York: public health system needs to be ready for the unexpected; need to have good surveillance; how to do epidemiology and respond quickly; forge strong relationships between the medical community and Public Health; engage the efforts of this non-traditional partners such as veterinarians and wildlife experts to deal with some of these more exotic diseases.
- In the United States in 2001: 69,000 dead birds - of those dead birds reported, almost half of them were tested and of those that were tested about a quarter of them were positive for West Nile virus. Most of them are crow or crow-related species, but there were 30% of other types of bird species that were infected. The number of crows that were tested that were positive was very high. The infection appears to be a very well transmitted in the crow population.
- Clinical manifestations of West Nile virus: only a small number of infected people, less than 1% develop the severe meningitis with brain infection and weakness and neurological disease. Main risk factor appears to be advanced age with a 12% case fatality rate. Symptoms include fever, weakness, nausea, vomiting, headache and altered mental status. Once patients can be discharged from the hospital over half of them are still not back to their baseline level of mental functioning. Only one out of three can walk unassisted and at one year post exposure, a large number still have fatigue, memory loss, muscle weakness and depression.

- Public Health response involved: reducing mosquito numbers and reducing human exposure to mosquitoes.
- West Nile Virus had not arrived in Washington State however it was expected in the very near future. Need to continue surveillance activities for West Nile Virus, both clinical and laboratory, and continue educational efforts with the community and health care providers.

Discussion:

Chair Edmonds inquired as to whether or not flu shots protected one against diseases such as West Nile virus.

Dr. Duchin responded that flu shots were specifically designed to target specific strains of influenza virus that were expected to appear in that given year. He added that flu shots were not effective against different strains of influenza virus that might appear in subsequent years and were not effective against other diseases.

Board Member Van Dusen asked whether or not the Department had seen a significant increase in measles in day care centers.

Dr. Duchin responded that they were very concerned about decreased immunization coverage among young and vulnerable children. Dr. Duchin mentioned that the measles outbreak in 2000-01 was not attributable to decreased vaccine coverage, although there had been outbreaks in urban areas of the U.S. where that had been a factor. Dr. Duchin stated that they had seen a very troubling increase in very young infants, less than one year of age, with serious pertussis infection. He said that there had been a big shift in the population most affected by pertussis from school children, young adolescents and young adults towards young children and infants who became extremely ill and needed to be hospitalized. He noted that that trend did not necessarily indicate a failure of vaccine in that population, but it might be related to decreased vaccine coverage in the older group that then lead to increased exposures of young children.

Board Member Conlin reflected on a recent personal experience in securing a tetanus vaccine, which prompted him to inquire about communication protocols and about the way in which providers assumed responsibility to keep their patients updated on vaccinations. He suggested that consideration might be given to re-engaging providers to get more active and aggressive on vaccination. He also inquired about the resource constraints or resource leads that public health might need to consider in order to their job.

Dr. Duchin responded that the Department worked primarily with the Childhood Vaccine Program, the Immunization Program for Children, and had close oversight over health care providers who were providing childhood immunizations. He said that the whole arena of adult immunization was a very important area and there was a lot of need for health care providers to pay very close attention to preventive medicine in general. He added that unfortunately anything that was preventive received short shrift resource-wise. Dr. Duchin stated that they clearly needed systems in place that would allow them to identify people for whom vaccines should be given at a clinical visit. Related to tetanus immunization, Dr. Duchin stated that routine immunization for adults included tetanus every ten years particularly those traveling to areas where tetanus or diphtheria might be a concern. He closed by stating that these issues were systems issues and there were technologically sophisticated means to address these issue, all that was needed was the corresponding dedication of resources.

Board Member Conlin stated that there appeared to be one area where a modest amount of resources could have a major impact and perhaps the Board should be consider that in the upcoming budget cycle.

Dr. Plough replied that the Department had extensive needs. He mentioned the current resurgence of sexually transmitted disease and HIV, which he found equally compelling. He stated that the Department had a number of unfunded challenges. He added that they would be addressing those challenges in more detail at the August work session. Dr. Plough stated that the Board, the City and the County recognized that the future challenge to Public Health required a broader and more sustainable funding base that what was currently in place.

Board Member Conlin inquired of Chair Edmonds whether or not there had been any discussion about the prospect of a public health levy

Chair Edmonds responded that the County Council had not discussed the possibility for a public health levy or any type of levy. She added that they would have discussed the mechanics of a levy. She stated that public health funding was a serious concern and she thought their first strategy should be directed towards the State Legislature because they had a responsibility for funding Public Health.

Board Member Thompson reflecting on Board Member Conlin's observations, stated that he thought there should be a mechanism developed so that individuals could keep their own immunization record in the same way that some parents maintain them for their young children.

Harborview Bond overview:

Dr. Plough introduced Ms. Elise Chayet, Director of Planning for Harborview. Ms. Chayet provided the Board with an overview of the project and focused on those parts of the project that had direct implication for the Department. Ms. Chayet noted that the actual bond project was for the purpose of seismic stabilization. Using maps she showed the Board how the design and building project would evolve over time.

Ms. Chayet stated that they were currently in the design phase. She added that the project was being managed by the University of Washington, Capital Project Office, with oversight being provided by the Oversight Committee consisting of representatives of the County, the Harborview Board of Trustees and the University of Washington. She stated that the Oversight Committee continued to meet on a monthly basis to oversee the design development process. She outlined the next steps including: hiring architects, doing site work, technical reviews, looking at sequencing, demolition, traffic, and confirming the scope and budget. She stated that part of the County Council review process required that they come before the County Council with the scope schedule and budget in the early part of 2003. At that point if they approved the scope schedule and budget, they would then appropriate funds for the schematic design phase of the project.

Board Member Van Dusen asked what Harborview would do if Harborview Hall was deemed to have historical significance and therefore could not demolished.

Ms. Chayet responded that Board Member Van Dusen's question related to seismic vulnerability and what could potentially be upgraded and what potential functions could be housed in the building. She added that the building not only had seismic vulnerability but it also did not have an air conditioning system and the electrical was tapped out. She stated that they had done Environmental Impact Statement recommendations on how to reuse

some of the more historical elements of the building in the other structures they hoped to maintain and they hoped they could work through some compromise with the Landmarks Board.

Board Member Conlin commented that it could be an interesting and frustrating process to go before the Landmarks Board, but ultimately the Board did make decisions that reflected the economic possibilities of historic preservation. He encouraged Ms. Chayet to be persistent and make their case as needed.

Chair Edmonds called for final questions. There being none, the meeting was adjourned and Board members prepared to tour public health programs located on the Harborview Campus.

KING COUNTY BOARD OF HEALTH

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Carolyn Edmonds, Chair